1055: CHANGES IN RENAL CALCULI COMPOSITION IN THE WEST MIDLANDS: A 20 YEAR EXPERIENCE

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Aim: Renal colic is a common presentation to accident and emergency departments throughout the UK. The aim of this study was to evaluate renal calculi composition and to assess changes over a 20 year period.

Methods: We performed a retrospective review of the stone analysis of renal calculi in 2721 patients over a 20 year period (1991-2010). The patient demographics were recorded and the location and size of the stones were analysed.

Results: The predominant stones were calcium oxalate (60.1%), calcium phosphate (15.8%) and uric acid (5.4%). The period from July to September had the highest frequency of renal calculi. There was a significant increase in the incidence of both calcium oxalate and uric acid stones in comparing the 2 groups ($p<0.05$). For the period 1991-1995, oxalate stones accounted for 51.9% and uric acid stones accounted for 2.8%. The incidence of calcium oxalate stones increased to 74.8% for the period 2006-2010, and uric acid stones increased to 6.8%.

Conclusion: The spectrum of renal calculi in our catchment area is comparable to the rest of the UK. The increase in incidence of both calcium oxalate and uric acid stones is possible due to a western diet and increase in sedentary lifestyle.

1056: EXPERIENCE WITH LAPAROSCOPIC RADICAL CYSTECTOMY IN A DISTRICT GENERAL HOSPITAL

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Aim: To evaluate early outcomes following laparoscopic cystectomy (LC), performed by a single surgeon, at Queen Alexandra Hospital (QAH), Portsmouth.

Method: A retrospective analysis of patient records coded as undergoing 'cystectomy' and 'laparoscopic procedure' at QAH since 2007.

Results: LC was performed in 25 male and 5 female patients, with a mean age of 68. Post-operative histology demonstrated 60% muscle-invasive (pT2-pT4) disease, of which 88% was transitional-cell carcinoma (TCC). 27% had recurrent high-grade superficial TCC (G3 pT1) or carcinoma-in-situ. 86% of patients had negative post-operative margins. Positive lymph nodes were identified in 17%. Mean hospital stay was 10.5 days. 40% of patients had no immediate complications. Early complications included ileus, chest, urinary or wound infections, mechanical bowel obstruction and one myocardial infarction. 7 patients were followed up elsewhere. At minimum 3 months, 70% of local patients demonstrated no pelvic recurrence and 57% had no evidence of nodal or metastatic disease progression. 57% have experienced no long-term complications. A minority developed uretero-ileal strictures, recurrent UTIs or pelvic abscesses. To date, mortality of all causes is 39%, 13% are undergoing palliation and 48% remain well.

Conclusions: As uptake of LC continues, early data from QAH demonstrates comparable oncological outcomes to open surgery.

1059: IS COMPUTED TOMOGRAPHIC UROGRAPHY OF THE UPPER URINARY TRACT THE GOLD STANDARD IMAGING MODALITY FOR PATIENTS WHO PRESENT WITH HAEMATURIA?

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Aim: To determine in patients who present with macroscopic haematuria if CT urography (CTU) is indicated as an imaging mode for the upper urinary tract as compared with Ultrasound (US).

Methods: We conducted a prospective study on consecutive patients who were admitted to our Trust with macroscopic haematuria from July to October 2012. All patients underwent a CTU or a renal US to image the upper tracts. Patients with known urinary tract malignancy or recent urological surgery were excluded.

Results: Of 83 patients that required hospital admission for haematuria, 26 were excluded. 17 patients (31%) had an inpatient US urinary tract as first line investigation with a mean wait of 3.2 days (range 0-28). 33 patients (58%) had an inpatient CTU with a mean wait of 2.9 days (range 0-25). CTU demonstrated superior ability at imaging the renal tract in patients who had both types of imaging with 4 patients displaying lesions on CTU that were not visible on US.

Conclusion: In our institution CTU has been demonstrated to have a diagnostic value than US when suspecting upper tract malignancy. We conclude that CT Urogram is accessible and should be first line radiological investigation in patients with haematuria unless contraindicated.

1107: DISPELLING UROLOGICAL MYTHS – ARE WE DOING ENOUGH?

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Introduction: Misconceptions are frequent amongst junior medical trainees, with gaps in knowledge leading to poor understanding of common presentations. We explored this premise within the context of commonly encountered urological presentations.

Methods: A questionnaire-based assessment of 67 year 1 Foundation doctors (FY1) was conducted to assess the prevalence of common urological myths.

Results: Our response rate was 100% with 28% of FY1's believing that a period of 7-days must elapse before checking PSA following DRE. 16.5% of FY1's were under the impression that vasectomy can negatively impact testosterone levels leading to erectile dysfunction. 12% of respondents felt that patients with prostate cancer required urological expertise to safely insert a urethral catheter. 97% of FY1 trainees were unsure regarding the management of haemo-dynamically stable patients with high-pressure chronic retention.

25% of FY1 trainees felt that haematuria in a patient undergoing anticoagulation therapy did not warrant urological investigation. 16.5% of FY1's believed that renal cysts were benign, needing no further assessment.

Conclusion: As a specialist trainee group we have a duty to seize educational opportunities when teaching at undergraduate and Foundation levels to educate and dispel myths, whilst promoting an improved understanding of the care of the urological patient.

1108: AN AUDIT ON INPATIENT NEPHROSTOMIES; PLANS TO OPTIMISE A SATURATED SERVICE

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Introduction: For busy urology departments' communication with the interventional radiologists is challenging. Interventional radiologists do not see their patients before a nephrostomy. They rely on doctors to provide them with the correct information so they can proceed. This audit analyses whether patients, at our hospital, get their nephrostomies swiftly and according to the seriousness of their obstructive uropathy.

Method: Thirty-five nephrostomy inpatients from 2012 were selected at random. The patients were divided into two groups. Emergency patients were classified as either single kidney patients with obstruction or patients with sepsis and obstructive uropathy. Urgent patients were classified as patients with obstructive uropathy.

Results: Fourteen patients had emergency nephrostomies, 19 had urgent nephrostomies, and 2 could not be triaged. Emergency patients were treated with a nephrostomy at a mean time of 37.9h (1h-249h) after admission, but at a mean time of 10.13h (0.5h-68h) after being requested. Urgent patients were treated with a nephrostomy at a mean time of 100.6h (6.5h-366h) after admission, but at a mean time of 6.1h (2h-28h) after being requested.

Conclusion: Many emergency and urgent nephrostomy patients experienced delay. We are trialling a proforma to present the radiologists with the correct information and improve our nephrostomy service.

1109: URO-ONCOLOGY EMERGENCY ALERT SYSTEM – EVALUATION OF A NEW SERVICE

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